Project CORE: Coordinating Optimal Referral Experiences

Implementing eConsults and Enhancing Referrals

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Project CORE: Coordinating Optimal Referral Experiences

3 Problems at Interface of Primary care and Specialty Care

1. Poor access to specialty care for patients

2. Poor communication/coordination between PCPs and specialist colleagues

3. Wide variations in care
Using Specialists Wisely...

Referral volume to specialists has more than DOUBLED in a decade (1999-2009)\(^1\)

For common chronic conditions, more than 75% of visits to specialists are for established patients\(^2\)

PCPs & specialists agree that many patients seen by specialists could be managed by primary care\(^3\)

\(^1\)Barnett 2012; \(^2\)Hollingsworth 2011; \(^3\)Gleason 2014
Poor Access to Specialists: Implications for an AMC

- Decreased Quality of Care & Patient Satisfaction
  For patients who need timely specialty input

- Crowding Out
  Loss of higher revenue patients

- Decreased Referrals
  From community PCPs & internal leakage

- Impairs Negotiations
  For payers who include timely access as bargaining point

- Inefficiency → Waste
  In shared risk/global payment models
The Primary Care & Specialty Care Interface

Then:

PC – Specialist Communication

Now:

Fragmentation

↓ Quality  ↑ Costs

CORE Coordinating Optimal Referral Experiences: Implementing eConsults and Enhanced Referrals
Patient Referrals
A Linchpin for Increasing the Value of Care

The success of accountable care organizations (ACOs) under global payment may depend in part on a common yet poorly understood clinical decision: the patient referral in the outpatient setting. Fundamental to collaboration among physicians and other health care professionals, patient referrals have been largely ignored in the payment reform debate.

Referral rates in the United States more than doubled from 1999 to 2009, with about 10% of outpatient visits resulting in a consultation or visit to another physician. Referrals seem to be both underused and overused, with clinical information often poorly transferred between physicians and frequent confusion between primary care physicians and specialists over the specialist’s role. Yet little is known about referrals. By systematically measuring and evaluating referrals in their physician networks, ACOs may be able to better target efforts to improve care coordination and reduce spending.

Referrals may be driven by a number of factors. Physician knowledge gaps due to specialization create a natural demand for referrals. Time pressures on outpatient clinicians may intensify this demand, because the number of physicians was 3.0 times greater in the same comparison, correlating with imaging, diagnostic tests, and minor procedures used on the order of 1 to 3 times as frequently. Surveys of primary care physicians suggest that for a patient with a given clinical profile, the largest variation in clinical decision making between high- and low-spending regions was in the likelihood to refer.

Referrals also affect prices. Given fee differences across private payers, shifting referrals from more expensive to less expensive clinicians and health care organizations may garner price discounts. Among early ACOs in Massachusetts, initial savings measured through claims were largely achieved by referring patients to physicians and facilities that charged lower prices, consistent with early efforts by these ACOs to control referral patterns.

In addition, referrals may affect quality. Fragmentation of care increases with the number of physicians a patient sees, reflecting the challenges in communication and teamwork among physicians in a complex delivery system. Medicare beneficiaries with chronic diseases such as heart failure or diabetes see a median of 8 to 10 physicians in a year, and the typical primary care physician needs to coordinate care with hundreds of other physicians for a panel of patients. Poor continuity of care is associated with more preventable hospitalizations, complications of...
Referral Rates are Highly Variable Across PCPs

(Referrals/100 PC visits; each bar represents a single provider at one AMC)
Project CORE Goals

By improving care delivery at the primary care – specialty care interface, the CORE model seeks to:

- Improve **specialty access**
- Enhance **primary care comprehensiveness**
- Reduce **unwarranted variation** in referral thresholds
- Improve **communication and coordination** between primary care and specialists
- Improve **quality and convenience** for patients
- Control **costs of care**
AAMC receives 3 year, $7M award from CMMI

Sept 2014

AAMC, with UCSF and 2 data partners, convene 5 AMCs to implement the CORE model (eConsults & enhanced referrals)

The CORE model implemented across 15+ medical & surgical specialties

March 2016

Program expansion to 7 additional AMCs (outside of the initial CMMI grant funding)
12 Participating AMCs

University of Washington
University of California, San Diego
University of Iowa
University of Wisconsin
Dartmouth-Hitchcock
University of Virginia
Greenville Health System
University of Michigan
Ohio State University
ECU Physicians
Vidant Health
Wake Forest Baptist Health

CMMI Collaborative
CORE2 Collaborative

AAMC
Elements of the CORE Model

1. **Improve communication** through optimized EMR workflows

2. **Improve coordination** through care coordination agreements

3. **Improve access** through introduction of eConsults
   - Align incentives for providers

4. **Improve clinical alignment** of PCP and specialist through point-of-care decision support

5. **Seek to create a culture** of trust, partnership between PCPs and specialists
Optimizing Care in the EMR

My patient needs to see a specialist about a specific clinical issue.

Enhanced Referral

I appreciate having a clear clinical question and relevant data in the EMR to help make the most out of this in-person visit.
Optimizing Care in the EMR

My patient needs to see a specialist about a specific clinical issue.

I have a clear clinical question for a specialist to help me manage my patient’s care plan.

Enhanced Referral

I appreciate having a clear clinical question and relevant data in the EMR to help make the most out of this in-person visit.

PCP

I reply to the PCP with my recommendation and next steps for the patient so that the PCP can continue managing the patient’s care.

Specialist

Specialist
University of Iowa HealthCare
Examples of e-Consultations

Paul James MD
Professor and Chair
Dermatology e-Consult

Clinical Question: Psoriatic lesions versus actinic keratosis.

This is a 62 y.o. male with long-standing history of mild psoriasis since childhood. He has significant solar damage over the forearms (L>R). Over the last 2 years he has noted new lesions on the forearms which he interprets as psoriasis but I am concerned about actinic keratosis.
Left Arm Photos
Consultant’s Response

Keratotic papules on the left arm are concerning for actinic keratosis (arm that hangs out driver side window) but it is impossible to distinguish with absolute certainty in this case. The lesions on the right arm and elbows appear to be more consistent with psoriasis and benign keratoses. No lesions appear to be concerning for non-melanoma skin cancer at this time.
1. At some point in the Fall (September - November), consider topical Efudex (fluorouracil 5% cream) treatment to the dorsal forearms and dorsal hands: apply twice daily for 2-3 weeks, then stop. Patient will experience redness, scaling, and discomfort- that is normal. Counsel patient to stop at any point if he develops significant irritation.
2. Recommend regular use of broad-spectrum sunscreens SPF>30.
3. Recommend liberal use of emollients- such as white petrolatum ointment (Vaseline), Aquaphilic, Vaniply ointment, Vanicream, CeraVe moisturizing cream, or Cetaphil moisturizing cream- applied at least twice daily and immediately after bathing or swimming.
4. Recommend triamcinolone 0.1% cream applied to the elbows twice daily for 2 weeks, then twice daily 2-3 days per week as needed. Do not apply to the face, armpits, or groin.

Dermatology Staff Physician (staff)
My question is about diagnosis of early RA vs. other serious rheumatological disease.

This is a 36 y.o. female South Korean with classic history of bilateral PCP, MCP stiffness, swelling and pain. No warmth and exam is unrevealing. 2 year history of progression. FH is remarkable for mother and MGM with Rheumatoid Arthritis. X-rays and labs are unrevealing. Should I continue NSAIDs or referral now to consider DMARD?
Rheumatologist’s Assessment

I personally reviewed this patient’s recent hand films and agree with the findings as recorded (normal films, no erosions). I also reviewed lab results and her recent clinic note documenting several years of symptoms, progressive AM stiffness and pain affecting hands, but no objective swelling on exam. Positive family history of RA. Creatinine normal today, but otherwise no basic labs since 2013, at which time there was anemia. **ANA is pending.** Both RF and CCP are negative.

**Assessment:**
- RA is unlikely given absence of objective swelling after 2 years of symptoms, normal ESR, CRP and negative RF and CCP
- A lupus arthritis could cause this degree of hand pain & stiffness without objective swelling.
Rheumatology Recommendations

Agree with checking ANA (pending)
- recommend that you also check a CBC with differential to rule out cytopenia or unexplained anemia and Urinalysis with micro.

[in general, if you have enough suspicion for lupus to order ANA, you should also check CBC with diff, creatinine, & urinalysis if they have not been done recently].

If all of the above are normal, I think you are fine to continue NSAID and regular follow-up without formal rheumatology consult (until or unless there are additional problems to raise concern for autoimmune disease. Occupational therapy consult may be helpful for hand pain ("evaluate and treat").

If the ANA is positive:
Please add-on the following labs: SSA, SSB, Smith, RNP, & dsDNA. Will then convert this to formal consult for arthritis.

Please let me know if you have any questions.
Disclaimer

The service provided through the e-Consult service is different from the diagnostic services typically provided by a health care provider. The e-Consult is based on the information available to me and is furnished without the benefit of a comprehensive evaluation or physical examination. Therefore, I may not be aware of information that might affect my opinion of the patient's diagnosis and treatment. By deciding to engage this service, you acknowledge and agree that: (1) you are aware of these limitations and agree to assume the risk of these limitations; and (2) no warranty or guarantee has been made concerning any particular opinion, result, or cure of a condition addressed via the e-Consult service.
Program Impact
Primary Care Faculty Usage of eConsults

- DH: 70%
- IOWA: 88%
- UCSD: 76%
- VIRGINIA: 68%
- WISCONSIN: 90%

*Cumulative use through July 2016

Source: AMC Monthly Reports (July 2016)
CMMI Collaborative: eConsult Volume

September 2014 – July 2016 (Q1-Q8)

7,709 eConsults completed
Referral and eConsult Rate for Live Program Specialties at 1 AMC

Q1 2014: 20.75
Q1 2016: 18.26
Provider Satisfaction Survey

PCP Survey: I am highly satisfied with this eConsult response.
89% of PCPs agreed with the statement. Results based on 316 PCPs at 5 AMCs

Specialist Survey: Was this eConsult question appropriate?
89% of specialist eConsultants said Yes. Results based on 693 responses from specialist eConsultants at 5 AMCs
Primary Care Physician Survey

*In the absence of an eConsult option, what would you have done?*

- **46%** would order a *standard referral* visit to the specialist
- **40%** would conduct a *“curbside” consult* (contact specialist through pager, phone, email, inbasket)
- **14%** would search *medical reference/clinical guidelines* or other

*Results based on 316 responses from PCPs at 5 sites*
Impact of eConsults

~8,000 eConsults completed by PCPs thru August 2016

46% would have sent a referral

~3,600 avoided referrals

40% would have curbsided the specialist

~3,200 avoided curbsides
UCSF Results: Access

Specialty care in ≤ 14 days

- Pulmonary
- G.I.
- Nephrology
- All 12 Medicine Subspecialties

Baseline Period
- Pulmonary: 20%
- G.I.: 20%
- Nephrology: 80%
- All 12 Medicine Subspecialties: 80%

Intervention Period
- Pulmonary: 60%
- G.I.: 40%
- Nephrology: 100%
- All 12 Medicine Subspecialties: 100%
UCSF Results: Increased External Referrals

Arrived New Patient Visits to UCSF Medicine Specialties

- With Internal PCP
- With External PCP

[Graph showing the number of new patient visits to UCSF Medicine specialties from November 2012 to October 2013, with a clear increase in external referrals from April 2013 onwards.]
What We’re Hearing…

“This model is right for our patients, our organization, and healthcare in general.”
– Academic Health System CEO & President

“I have found it a very helpful way to get answers to my questions & learn at the same time, while getting my patients’ needs addressed.”
– AMC Primary Care Physician

“eConsults reduce the length of waiting for in-person consultations…it is the future of medicine…”
– AMC Specialist

CORE Coordinating Optimal Referral Experiences: implementing efficient and enhanced referrals

AAMC
eConsults

Cathleen E. Morrow MD
Chair and Associate Professor
Department of Community and Family Medicine
Geisel School of Medicine at Dartmouth
Dartmouth Hitchcock Medical Center
Joy in Practice!

• Timely answers to nagging questions that would keep you awake at night
• Reduction of the worry-quotient
• Patient convenience, appreciation
• More likely to ask: not interrupting colleagues, knowledge that specialist is accruing RVU’s, more focused education
• Increased specialty awareness of PC provider needs
The Medical Center View

- Increase access to specialty services: particularly important for the over-burdened ones
- Increase appropriate live consults
- Cost of care, value
- Increase connectivity between in and outpatient spaces.
Project CORE at GHS: Why, How and Challenges

September 27th, 2016
Sean Bryan, MD, FAAFP
Associate Professor and Chair, Dept. of Family Medicine
Business Needs

• Become a high performing multi-specialty group
• Follow more evidence based medicine protocols
• Reduce unnecessary utilization of care
• Improve standardization where appropriate
• Improve patient-centered communication between primary care and specialists while reducing fragmentation of care between providers
• Position GHS to succeed in the transition to value based alternative payment models
• Better population health management by improving patient access to specialty care, as well as reduce the cost of care for patients
Business Objectives

• Reducing total cost of care for primary care patients
• Improving quality of care through enhanced timeliness of specialist input and improved continuity of care within the primary care setting
• Increasing patient satisfaction by improving access to specialists for specialty care
Getting the Support Necessary

• Obtained commitment from GSH leadership - COO, CIO, CMIO, and Chairs by showing the benefits and success obtained by other AMCs, and the alignment with:
  – PCMH
  – Medical neighborhoods
  – The IHI Triple Aim
  – GHS’ strategic vision:
    “To transform health care for the benefit of the people and communities we serve”

• Chairs, Vice Chairs and Primary Care lead physicians in Family Medicine and Internal Medicine actively marketing the initiative to:
  – Colleagues
  – Administration
Challenges

• Other Health System Strategic Priority
  – Change in the current governance structure from governmental to private not for profit

• Epic implementation / IT resources availability
  – 5 hospitals went live on Epic in February 2016
  – 2 hospitals and many practices go-live on Epic on October 1, 2016

• Primary Care Lead Physician challenges
  – Large territory to cover
  – Many new hires
  – Protected time
    • Family Medicine Vice Chair for Clinical Affairs had too many competing priorities to handle this role alone
    • Chair of Internal Medicine has agreed to support up to 0.25 FTE for newly identified Primary Care Lead Physician
Current Status

• PCP lead and operation team identified and are actively participating in the project
• Epic team member expected to join the team in November, after the last Epic go live
• Team of specialists and PCPs are reviewing and tweaking the Cardiology and Endocrinology eConsult and Enhanced Referral templates supplied by UCSF
• Investigating what will be the 3rd and 4th specialties to go-live so review of templates can begin, considering Neurology and Pulmonology
• Planned go-live for the first two specialties: February 2017
Scaling & Sustaining the CORE Model

- Identify next cohort of AMCs
  - To create an “innovation implementation” collaborative

- AAMC work with CMS
  - On reimbursement and a sustainable payment model

- Broaden model to inpatient care
  - To facilitate transition of care to community-based care team

- Expansion at current AMCs
  - To include children’s hospitals and external, community PCPs

CORE
Coordinating Optimal Referral Experiences: Implementing eConsults and Enhanced Referrals
THANK YOU!

To learn more or to request additional information, visit www.aamc.org/projectcore or email projectcore@aamc.org.

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Learn
Serve
Lead

Association of American Medical Colleges
Implementing CORE: a few lessons

Assembling the team
“Selling” the model to key stakeholders
EMR build
Identifying specialist eConsultants
Customizing templates
Training providers
Shifting the culture
Data and quality assurance
Innovation in Action

As of 2016, across the participating AMCs, over 1.2 million primary care patients can benefit from Project CORE through timely clinical input, greater convenience, improved access, and lower costs.

12 AMCs
2,000 Primary Care Providers
1.2 Million Primary Care Patients